reviews

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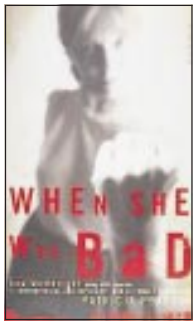
When She Was Bad: How Women Get Away with Murder

Patricia Pearson



Virago Press, £9.99, pp 304
ISBN 1 86049 488 9

Rating: ★★

North American data show that between the 1960s and 1990s arrests of women for aggravated assault trebled, arrests for robbery quadrupled, and the homicide rate increased by a third. Arrests of women for violent crime grew at more than twice the rate of those for men.

With figures like these, Patricia Pearson attempts to challenge the prevailing belief that female violence is such an extreme departure from the feminine traits of gentleness and compassion that mental illness must be invoked to explain it. Until recently, only 8% of studies on human aggression focused on women, and Pearson claims that this accounts for why the true extent of female aggression has been underestimated. She cites many examples of violence from the anthropological literature. For example, on Margarita Island, off the coast of Venezuela, women are clearly more violent than men, with female public brawls over paternity issues a common sight. The men are regularly assaulted by women relatives, in order to teach them "respect" for their womenfolk.

The book amasses some convincing evidence that the female contribution to violence has increased, and there is an original discussion of how much women might directly instigate violence between men. But, as is inevitably the case when a journalist tackles an issue, the author is too uncritical of her own thesis. There is too much reliance on the gripping anecdote to carry an argument rather than unearthing relevant data.

Whether the rise in female externally directed aggression might explain the recent drop in female suicidal activity compared with that in men is a matter of keen interest to psychiatrists, but this is glossed over. Similarly, Pearson neglects the interactionist and cognitive perspectives, in which all violence is seen as the product of an interaction between protagonists, and the choice of aggression makes sense if you believe it will get you what you want and you have few alternatives. The book also surprisingly fails to properly consider animal data, with the females of many species often being more aggressive than the males. But there is a useful take home message for clinicians: it might be wise to take the same precautions over personal safety when seeing an unknown female patient as you would with a new male patient.

Yet the anecdotes do stop you putting the book down and reaching for a more rigorous criminological text. For example, in a discussion among Los Angeles women attending a course on how to shoot for self defence, taught by the author of the book *Armed and Female*, it is explained that they are much better shots than men "because they don't get into pecker contests." The male smile freezes when he learns that in the United States today 12 million women have their own handguns and that a favourite graffito in women's toilets is, "So many men. So little ammunition."

Raj Persaud, *consultant psychiatrist, Maudsley Hospital, London*

Epidemiology Kept Simple: An Introduction to Classic and Modern Epidemiology

B Burt Gerstman

Wiley-Liss, £25.95, pp 299
ISBN 0 471 24029 X

Rating: ★★★

Epidemiology is an eclectic discipline comprising facets of sociology, statistics, medicine, and demography. Although its development may be traced back to the scientific revolution of the 1600s, it was not until the 19th century that it was recognised as a subject area in its own right. Knowledge of the occurrence, aetiology, and subsequent control of communicable diseases such as typhoid fever, smallpox, and cholera stemmed from early epidemiological studies. Indeed, John Snow's investigation of the infamous 1854 cholera epidemic in London, widely known as the Broad Street pump, is ensconced in epidemiology folklore.

The emergence of non-communicable diseases such as coronary heart disease earlier this century led to epidemiology occupying a wider remit. Modifiable determinants of coronary heart disease were identified from large scale epidemiological investigations beginning with the Framingham and the seven countries cohort studies. These determinants were subsequently labelled risk factors, and the misconception that coronary heart disease had a sole aetiology was dispelled. Findings from these and other epidemiological studies have been used by healthcare providers to more effectively target candidates for coronary heart disease and in turn initiate prevention.

Today, a growing body of professionals—from health education, environmental and occupational health, and health service administration, in addition to medical science students—are required to have some knowledge of the foundations of epidemiology. In an effort to supply the demand from such disparate backgrounds a somewhat bewildering array of new epidemiology texts and revisions of classics has appeared. In *Epidemiology Kept Simple* Burt Gerstman has devised a text to match this diverse range of learning needs.

From the perspective of a postgraduate student of epidemiology, he succeeds in covering the fundamental concepts, principles, and methods of classic and modern epidemiology. These are illustrated by a blend of real life examples, exercises, and occasional humour (such as the problem of how many epidemiologists it takes to change a light bulb: the answer is six, one to change the bulb and five to address potential biases). The discussion of the strengths and shortcomings of different study designs, the establishment of causation from associational data, and the evaluation of methods of disease identification were of particular interest and succinctly dealt with.

I found this to be a useful publication among an epidemic—if you'll forgive the description—of epidemiology textbooks that will provide much competition for this work.

David Batty, *doctoral student, Exercise and Health Research Unit, University of Bristol*

The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures

Anne Fadiman

Farrar Straus and Giroux,
£7.73, pp 352
ISBN 0374 525 641

Rating: ★★★★

Merced is a town in a depressed area of California's central valley with a population of 61 000. A fifth of the population are Hmong refugees, and the proportion is growing as the Hmong value children and have plenty of them. Most of the older Hmong are illiterate, speak no English, and live on welfare benefits. The younger ones do well, rather better than white children in school and at university. No one knows where the Hmong originated; they are lighter than most Asian people and don't have an epicanthal fold to their eyes. They reached China over 1000 years ago, and in the past century responded to persecution by migrating on foot to Laos, Thailand, and Vietnam. The Chinese called them the Meo, which means "bumpkin," "barbarian," or "people who sound like cats."

In recent times many Laotian Hmong have fled to the United States, partly because they had fought with the US forces in the South East Asian conflict and had been given the impression that they would be treated well in the United States. Refugee organisations have dispersed them around the country, from where they migrate to the parent community in Merced. Here they can speak their own language, meet enough Hmong from other tribes to ensure that their children can marry (marriage within a tribe is forbidden), and buy Hmong food from Hmong food shops.

The Lee family arrived in Portland, Oregon, with their seven surviving children, six of whom had been born in Laos and one in a refugee camp. A further five children had died in infancy. Those born in Laos had their placentas buried beneath the mud floor of the hut: a placenta is a jacket, and when a person dies their soul must migrate back to their birthplace to reclaim the jacket. Lia, the Lees' youngest child but one, was born in Merced County Hospital, and thus her placenta was callously discarded. When Lia was 3 months old her sister slammed a door, and Lia immediately rolled her eyes and had an epileptic fit. To her family this meant she was ill, but it also meant that she was special—"the spirit caught her."

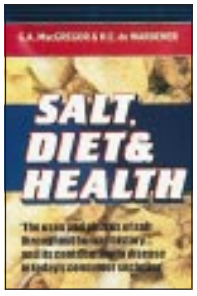
Lia's tale becomes a tragedy of Shakespearian dimensions. Over the next four years she went to the emergency room hundreds of times, often in status epilepticus. Her prescription was changed 22 times. Her parents found that most of the drugs made her worse and withheld them. If any drug seemed to make her better they gave her extra. Every time she attended, one of the two dedicated supervising paediatricians, Peggy Philp and Neil Ernst, would come and see her, even at 3 am. Peggy and Neil are married to each other. They could not fathom whether Lia was convulsing despite her drugs or because she wasn't getting them. Neil felt that Lia's father was stonewalling him, and Peggy felt that Lia's mother was a bit crazy because, on the rare occasions when a translator was present, her answers didn't make sense. A brigade of visiting nurses burnt out by visiting Lia's home and trying to educate her "non-compliant" mother. To make things worse, the Lees doted on Lia, allowed her to rampage around, and totally spoiled her. To the nurses, Lia's parents seemed courageous and polite but obstinate.

Anne Fadiman's book has won accolades in the United States, including the National Book Critics Award. It is unputdownable, heartbreaking, scrupulously researched, and riveting. I would give my right arm to write a tenth as well. I have read it twice, will read it again, and will give it to friends for Christmas. What makes it additionally interesting is the response from Lia's doctors and family (which can be perused on the Amazon Bookshop's website, http://www.amazon.com).

Caroline Richmond, *writer and editor in medicine and biosciences, London*

Salt, Diet and Health

G A MacGregor, H E de Wardener



Cambridge University Press,
£14.95, pp 245
ISBN 0 521 63545 4

Rating: ★★★

Did you ever suspect that there might be an industrial conspiracy against a reduction in salt intake? MacGregor and de Wardener think so. On first browsing, their book looks like one of those populist texts, "Lose 50% of your weight in 2 weeks without effort and stay healthy." On the other hand, both authors are well known in the world of dietary salt. Other guarantors for credibility are the well selected and presented references, with most of the cited sources being credible journals.

I was quickly engaged by one of the most informative and entertaining books that I have read. It was almost exciting to learn about the history of salt and the historical role it has played in society: the matter of how salt was used as a commercial and fiscal product to increase the revenue of the ruling authorities is addressed briefly but comprehensively. The book then swiftly moves to the heart of the matter: the adverse relation between salt intake and health.

Two recent articles in *Science* have concluded that there is little evidence that reducing dietary salt is beneficial, but MacGregor and de Wardener present scientific findings to support their premise in a convincing way. They manage to put the size of the problem, and its consequences, in perspective, and their presentation is spiced with a balanced view of an interesting issue: why hypertension is almost twice as common in black Americans as in white Americans in the United Sttes.

The chapter on industrial conspiracy is the most fascinating, and the authors' allegations are well presented, discussed, and referenced. Some "good" reasons exist for the food industry not trying too hard to reduce the salt content of their products—processed foods provide us with 80% of our daily salt intake. The salt industry is a wolf in sheep's clothing, trying to deny or obscure the evidence that links salt intake to hypertension and subsequent stroke. These allegations have already caused controversy in the *BMJ*, and there is potential for more. One of the authors of the *Science* articles, we are told, has been a consultant for the Salt Institute, a food industry organisation.

The book is written for both lay people and medical professionals. Even though the reader is informed that atherosclerosis means "furring of the arteries," I am not sure if a lay person would feel at ease with the graphs or with terms like "plasma angiotensin" and "ACE inhibitors." This minor reservation aside, it is clear that MacGregor and de Wardener have spent much of their scientific lives pursuing the association between salt and hypertension. They not only have a deep insight, but are able to convey their knowledge convincingly.

Marcus Müllner, *editorial registrar, BMJ*

Reviews are rated on a 4 star scale (4=excellent)

Public Health at the Crossroads: Achievements and Prospects

Robert Beaglehole, Ruth Bonita

Cambridge University Press, £17.95, pp 258
ISBN 0 521 59373 X

Making Sense of Public Health Medicine

J Connelly, C Worth

Radcliffe Medical Press, £17.50, pp 164
ISBN 1 85775 1868

Progress in Public Health

Ed Gabriel Scally

RSM Press, £19.99, pp 302
ISBN 0 443 05938 1

Rating: ★★★, ★★★, ★★★

Public health professionals perennially ponder the future and scope of their discipline, for good reasons. Their changing roles are largely determined by incessant reforms of the health sector, and their responsibilities are immodestly claimed to embrace anything relevant to the wellbeing of everyone. So are there any limits to, or at least priorities for, public health practitioners? Should they be involved in improving health care, or should they instead concentrate on improving income distribution, education, nutrition, and physical environments?

Three books address these questions from different perspectives. *Public Health at the Crossroads* provides the broadest overview, reviewing the changing influences on global health, developments in epidemiology, and public health organisation in wealthy and poor countries. Its inclusiveness is valuable, as are the data showing dramatic global trends and differences in health and the diverse country studies. *Making Sense of Public Health Medicine*, in contrast, focuses on the current preoccupations of public health physicians in the NHS. The authors are often refreshingly opinionated and critical, and they eclectically invoke different philosophical, historical, and political views to support their arguments. In *Progress in Public Health* leading UK writers review recent developments in subjects ranging from community development to small area statistics and from European integration to control of communicable diseases. The first book would be best for newcomers to public health and anyone wanting a summary of global health issues, the second for UK public health physicians and trainees, and the third for those wanting a more advanced update on UK research, practice, and ways of seeing.

Two revealing key words crop up repeatedly. The commonest is "challenge." It is often unclear whether challenge means threat, difficulty, priority, opportunity, or duty, and this ambiguity suggests either sophistication or confusion. The other key word is "advocacy." Beaglehole and Bonita, among others, believe that public health professionals should not be sucked into work on health care and should instead direct their energies into advocating a better and more equitable society. Sadly, the effectiveness of advocacy by public health professionals has yet to be shown. Surely, if a tiny number of marginal professionals want to change the world's economy, physical environment, and social ethos they need to know, on the one hand, their limitations and, on the other, how to maximise their political influence through organisations and alliances. Meanwhile, it should be recognised that power is where the money is—in healthcare organisations—and that harnessing and directing health care can help to prevent death and illness while saving money for more important things like jobs, education, and welfare.

Max O Bachmann, *senior lecturer in epidemiology and public health medicine, Department of Social Medicine, University of Bristol*

WEBSITE OF THE WEEK

www.christiangallery.com/atrocity Just imagine: one minute you're angrily combining images of aborted fetuses with text to make antiabortion propaganda on the web; the next your internet service provider has pulled the plug and you cease to exist (in cyberspace at least). However, the site does turn up again at www.riverpup.com/abortion/files.html. Quite a few people claimed to have cached the site in its entirety on the newsgroups, so it may be being published without the consent of its original owner. This shows the hydra-headed nature of the internet—censorship is not possible.

Christian gallery was a rabidly antiabortion site (see p 415) that published a list of doctors who performed abortions. Its author drew a line through the name of a doctor on a list after that doctor had been killed because he had performed abortions. The site was updated on the evening of the doctor's death. That the different views on abortion seem irreconcilable is well known: what is new is using the internet to publish intimidatory hit lists. But information is a two edged sword: after all, the addresses of clinics run by pro-choice organisations are available at www.plannedparenthood.org.

The common carrier status of internet service providers is still controversial: we don't jail a telephone company because people use it to arrange criminal activities. The freedom of speech lobby may have a point when they say that closing down such a site sets a worrying precedent, although Mindspring, the internet service provider involved, was certainly within its rights (see www.mindspring.net/prod-svc/users.html).

Shooting doctors to prevent the death of a fetus does seem morally inconsistent, but then US gun law means that this sort of thing will happen from time to time, so let's leave the web out of this one and concentrate on lawfully controlling the real life behaviours we abhor.

Douglas Carnall
www.carnall.demon.co.uk

PERSONAL VIEW

The emperor has no clothes on

Am I the only general practitioner in the country who finds it almost impossible to complete a modern consultation in the short time allocated? Am I the only one who regularly finds that his morning surgery has drifted perilously close to becoming his working lunch or even his afternoon session? And if everyone else does manage it, would someone be so kind as to tell me how. For it seems to me that there is a discrepancy between the sort of consulting we are encouraged to practise and what actually happens. There seems also to be almost a conspiracy of silence between practitioners in pretending that it can be done.

Now the problem might lie in the fact that I have only recently completed my general practice training. My registrar year acted as a fulcrum between the rigid protocols of hospital practice and the adoption of a new primary care mantle. But it was only a short conversion course and there is much for me to learn to become a competent general practitioner. There is a world of difference between the ritualised senior house officer approach to clerking a patient and the same patient being assessed in a morning surgery. The latter is often characterised by an alchemy of history taking, examination, and investigations resembling a wiring system in parallel rather than in series. Pattern recognition prevails, and well rehearsed polished algorithms are employed with an emphasis on what needs to be done rather than what could be done.

Nevertheless, I struggle to see how, in the six or seven minutes that the statistics tell us we have, I am to accomplish even fragments from the various models of the consultation that I spent a year learning about. Never mind the necessary social overtures and logistics of making an elderly patient comfortable, or gaining the confidence of a suspicious toddler. Never mind the missing blood results, ringing telephones, or "while I'm here" doctors' lists. Let us look purely and simply at the medical content. What needs to be accomplished? Some form of clinical assessment would seem to be essential and might involve trawling through a bulging docket of notes or some window gazing on the computer. A history and examination in whatever ratio is appropriate probably need to be carried out.

The patients' views need to be canvassed and an idea gained of their concerns and own ideas. Once an assessment has been made, time needs to be found, if necessary, to provide sufficient medical information to enable a discussion of the options that face the patient and the doctor. These options are of course evidence based and may require some contemporaneous research. Everything from the significance of diagnostic features to the predictive value of investigations and the value of prognostic markers is amenable to analysis.

Some reflection and a sharing of common understanding will conclude the topic under discussion, and then moves can be made to cover any relevant opportunistic health promotion or screening issues.

I am unable to believe that anyone, no matter how practised, can achieve these tasks in six or seven minutes. Labour saving devices and condensing techniques will all help, but will chip away only at the edges, leaving the core of the consultation alone. Yet the myth is perpetuated by the sheer number of consultations carried out each day, a million by my calculations, which must prove that it is possible. For so many people to be using a technique must mean that it is successful.

> Surely the time has come to retire the short consultation

It seems to me that little account has been taken of the progress that medical science has made over the past two or three decades. We are still using an operating system that was designed for another era, an era when less was known about the biochemistry of, say, depression, or the mechanics of poverty. Witness the FP8 form and the Lloyd George record. That was a data collection system ideal in its time, but the language today is of library databases and megabytes.

There has been a paradigm shift in the way that medicine is understood and the way that doctors work. It has always been a cerebral activity but it now thrives on a seemingly endless supply of information and facts. Statistics abound. Confidence intervals embrace relative risks, and genes emerge from the shadows. Applying this new understanding to the patient sitting in front of you on a Tuesday morning will take time, thought, and discussion. The complexity and uncertainty should be shared and not concealed.

This cannot be done in six or seven minutes. Surely the time has come to retire the short consultation—to consign it to the archives. It does neither the profession nor the consumer justice.

If you would like to submit a personal view please send no more than 850 words to the Editor, BMJ, BMA House, Tavistock Square, London WC1H 9JR or e-mail **editor@bmj.com**

Jonathan Easterbrooke, *locum general practitioner, Dorchester*

SOUNDINGS

Snow in Chicago

Twenty one inches of snow came down on Chicago in one day in the first week of January, in what was the third worst snowstorm of the century. For a few hours the city ground to a halt, its roads impassable, visibility reduced to a few feet.

Then out came the snowploughs, for this is a city that once voted a mayor out of office for failing to clear the snow promptly, and soon the main highways were opened again to traffic. Somehow, almost miraculously, the doctors and the nurses all made it to the hospital, as did the patients who had to, such as those on chronic dialysis.

Then the temperature dropped sharply, leaving the streets deserted but for rare ghost-like creatures shuffling through the snow, wrapped in shawls and covered up like the ladies of Isphahan. Some wore operating room masks—were they purchased or otherwise appropriated?—that made them look like strange exotic birds with large white beaks.

There were casualties. Cars got stuck in the snow, ran off the road, or collided with snowploughs. An abandoned baby was found frozen near a church. A young man slipped on ice and fractured two vertebrae. Others merely sprained ankles. A very important lady with presumed osteoporosis fell and smashed her humerus in many places. A patient with arteriosclerosis fractured his tibia and had a transient hemiparesis; his carotid arteries were found to be almost totally occluded—too far gone for extensive plumbing repairs. There were pneumonias—some classical, lobar in distribution with sputum rusty—as well as various viral syndromes with normal chest *x* rays, some of which were misdiagnosed and treated as bacterial pneumonias.

A young medical intern unexpectedly and inexplicably developed aortic dissection while shovelling snow and required emergency surgery. Attempts at snow removal also resulted in the usual crop of sprained muscles, and in a few heart attacks in men unaccustomed to strenuous exercise, vasoconstricted by the cold, and heedless of the widely publicised advice to avoid such sudden exertions—and perhaps delegate them to women and children.

Indicative of our times was the young woman admitted to my service after walking 10 hours in the snow looking for heroin. She had a rip-roaring pneumonia as well as extensive frostbite. She recovered minus three toes and said that she would never do it again.

George Dunea, *attending physician, Cook County Hospital, Chicago, USA*